

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3192

CERTIFICATE OF DEATH

Reg. Dist. No.

03185

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Retreat				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ada Virginia Baldwin				4. DATE OF DEATH Month Day Year Mar. 17, 1959 19			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1870		9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Ins. Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Baldwin				14. MOTHER'S MAIDEN NAME Virginia Hamilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-52-4978		INFORMANT Address Miss Elizabeth B. Fox, 627 N. Augusta Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral vascular collapse 154X DUE TO Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cachexia (c) Carcinoma, rectum.						INTERVAL BETWEEN ONSET AND DEATH 12 hr. 48 hr. 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October , 19 58 to March 17 , 19 59 , that I last saw the deceased alive on March 12 , 19 59 , and that death occurred at 12:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas J. Herbert M.D.				ADDRESS (Street, city or town, state) 46 Church Road Ellicott City, Md.			
PHYSICIAN'S NAME (Type) Thomas F. Herbert				DATE SIGNED 3/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 20/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR MAR 19 59		24b. REGISTRAR'S SIGNATURE William S. Throckmorton	

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216 J. A. Roberts

77-2-4078 Mine Inspection Report, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620,

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1175 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street, Chicago, Ill. 60610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3193

CERTIFICATE OF DEATH

03186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>15 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E Busch</u>		4. DATE OF DEATH Month Day Year <u>March 18 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W Busch</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E Rodgers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Helen Busch 2821 Glendale Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic cardiac decompensation</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>2 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 3, 1959</u> to <u>March 18, 1959</u> , that I last saw the deceased alive on <u>March 17, 1959</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thomas J Herbert</u> M.D. <u>46 Church Road</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Ellicott City Md</u> <u>3/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 21 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J Melville Jenkins 2713 Kirk Ave</u>		24a. RECEIVED BY REGISTRAR <u>MAR 20 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3194

CERTIFICATE OF DEATH

03187

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clarkland				d. STREET ADDRESS Clarkland			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PRISCILLA Middle PHELPS Last CLARK				4. DATE OF DEATH Month March Day 24 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1952		9. AGE (In years and birth day) yrs. 6	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Clark Jr				14. MOTHER'S MAIDEN NAME Lillian Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James Clark Jr, Ellicott City, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERY THROMBOSIS 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DEHYDRATION; INFLUENZA, VIRAL DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH ACUTE 2 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MASSIVE BRAIN DAMAGE, CONGENITAL; KERNICTERUS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1956 , to MARCH 23, 1959 , that I last saw the deceased alive on MARCH 23, 1959 , and that death occurred at 3 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3-24-59							
ACTUAL SIGNATURE Donald E. Fisher M.D.							
PHYSICIAN'S NAME (Type) Donald E. Fisher				Ellicott City, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-1959		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 240 3-18-59 et

3195

CERTIFICATE OF DEATH

03188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GUILFORD</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Died at her home"</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>HELENA</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>3/</u> Day <u>12/</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>3/</u> Days <u>12/</u> Hours <u>19</u> Min. <u>59</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>RICHARD H. HALL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA JANE JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs MARTHA BLACKSTONE</u> Address <u>Box-353H DUCKKEY LANE ELKBRIDGE, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extension of Infarction</u> (c) <u>Hypertension - Bronchitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 hrs</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured left 9th rib, 2/16/59</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>Fracture left 9th rib, Had week spell & Fall</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> p. m. <u>2/16</u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Lanesville</u> (County) <u>Howard</u> (State) <u>MD</u>							
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>59</u> , to <u>3/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/10</u> , 19 <u>59</u> , and that death occurred at <u>5:00</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B P Warren</u>				DATE SIGNED <u>3/12/59</u>			
PHYSICIAN'S NAME (Type) <u>B P WARREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASPURY CEMETERY</u>		22d. LOCATION (City, town, or county) <u>JESSUPS, MARYLAND</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>ROCKVILLE, MD.</u>		24a. REC'D BY REGISTRAR <u>MAR 16 59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS UNRECORDED

PREVIOUS UNCLASSIFIED

PREVIOUS UNDETERMINED

PREVIOUS UNKNOWABLE

PREVIOUS UNRECORDED

PREVIOUS UNCLASSIFIED

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PREVIOUS UNDETERMINED

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PREVIOUS UNCLASSIFIED

PREVIOUS UNDETERMINED

PREVIOUS UNKNOWABLE

PREVIOUS UNRECORDED

PREVIOUS UNCLASSIFIED

PREVIOUS UNDETERMINED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3196

CERTIFICATE OF DEATH

03189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Johns Lane		e. STREET ADDRESS St. Johns Lane	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUTHER Middle EYRE Last ISAACS		4. DATE OF DEATH Month March Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1899
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Inspector		10b. KIND OF BUSINESS OR INDUSTRY Howard County	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Crittendon Isaacs		14. MOTHER'S MAIDEN NAME Annie Eyre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-7275	
17. INFORMANT Mrs. Lillian Isaacs, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Squamous cell Carcinoma, Lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 36 hr. 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 57 , to March 10 , 19 59 , that I last saw the deceased alive on March 9 , 19 59 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Herbert M.D.		ADDRESS (Street, city or town, state) 466 Church Road	
DATE SIGNED 3-11-59			
PHYSICIAN'S NAME (Type) Thomas F. Herbert M.D.		Ellicott City, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-13-59	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS	
24a. REC'D BY REGISTRAR MAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

CERTIFICATE OF DEATH

2106

File No. 10

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "10-15-1900"]</p>		<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]</p>	
<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>		<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. COLOR [Faint text, possibly "White"]</p>		<p>9. RELIGION [Faint text, possibly "Roman Catholic"]</p>		<p>10. EDUCATION [Faint text, possibly "High School Graduate"]</p>	
<p>11. DECEASED AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>12. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>13. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>14. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>15. DATE OF DEATH [Faint text, possibly "11-1-1945"]</p>	
<p>16. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>17. SIGNATURE OF CORONER [Faint signature]</p>		<p>18. SIGNATURE OF WITNESS [Faint signature]</p>		<p>19. SIGNATURE OF DECEASED [Faint signature]</p>		<p>20. SIGNATURE OF NEXT OF KIN [Faint signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03190

3197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELICOTT CITY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELICOTT CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 FOREST ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES WYATT JENSON</u>				4. DATE OF DEATH Month Day Year <u>MARCH 9 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 17, 1884</u>	
9. AGE (In years last birthday) yrs. <u>74</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAY WORK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>ALFRED JENSON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-20-3368</u>			
17. INFORMANT <u>Joseph Simpson</u>				Address <u>ELICOTT CITY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/20/1958</u> to <u>3/9/1959</u> , that I last saw the deceased alive on <u>3/7/1959</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u> DATE SIGNED <u>3/9/59</u>							
ACTUAL SIGNATURE <u>William F. Cassaway</u> M.D.				PHYSICIAN'S NAME (Type) <u>William F. Cassaway</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN STAR</u>		22d. LOCATION (City, town, or county) (State) <u>CATONSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higginbotham</u>				ADDRESS <u>ELICOTT CITY, MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
MAY 17 1921		BALTIMORE	
DECEASED		MARRIED	
FEMALE		FEMALE	
AGE		AGE	
37		37	
RACE		RACE	
WHITE		WHITE	
BIRTH		BIRTH	
MAY 17 1884		MAY 17 1884	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE		BALTIMORE	
OCCUPATION		OCCUPATION	
HOUSEWIFE		HOUSEWIFE	
CAUSE OF DEATH		CAUSE OF DEATH	
TUBERCULOSIS		TUBERCULOSIS	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. F. JENNINGS		J. F. JENNINGS	
DATE		DATE	
MAY 17 1921		MAY 17 1921	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
J. F. JENNINGS		J. F. JENNINGS	
DATE		DATE	
MAY 17 1921		MAY 17 1921	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3198

CERTIFICATE OF DEATH

Reg. Dist. No.

03191

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 5½ mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, nr. 09X-2	
3. NAME OF DECEASED (Type or print) First Middle Last Clare Winberry Loesel		4. DATE OF DEATH Month March Day 21 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/89
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) East Arcade N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ? O'Neil		14. MOTHER'S MAIDEN NAME ? Hyland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 355-12-71774	
17. INFORMANT June W. Sanders		Address 131 Elinor Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 40 hrs. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Chronic Brain Syndrome with psychosis due to arteriosclerosis, diabetes mellitus, decubitus ulcer		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1/59, 19, to March 21, 1959, that I last saw the deceased alive on March 21, 1959, and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen Lee Magness		ADDRESS (Street, city or town, state) Taylor Manor Hospital DATE SIGNED 3/21/59	
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.		Taylor Manor Hosp. Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 25 1959	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Taylor Avenue Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dippel Brothers 7110 Belair Road		24a. REC'D BY REGISTRAR DATE MAR 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kama	

3018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3199 Item 2 Film 6239 3-16-59 et
CERTIFICATE OF DEATH

03192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaefer Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ellicott City Route 1 (Correct)</u> d. STREET ADDRESS <u>Old Montgomery Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Caroline H. (Carrie) Lupton</u> First Middle Last				4. DATE OF DEATH <u>March 9 1959</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-1888</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Strube</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Neeb</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Grace M. West-Old Montgomery Road</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/8</u> , 19 <u>59</u> , to <u>3/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>59</u> , and that death occurred at <u>1:00 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>46 Church Rd, Ellicott City, Md</u> DATE SIGNED <u>3-11-59</u> ACTUAL SIGNATURE <u>Thomas J. Herbert</u> PHYSICIAN'S NAME (Type) <u>Thomas J. Herbert</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar:13-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Herbert</u>				24a. REC'D BY REGISTRAR <u>1300 Eutaw Place</u> ADDRESS		24b. REGISTRAR'S SIGNATURE <u>MAR 12 '59</u> DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3-28

MINI PROMD

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Date of burial</p>	
<p>9. Name of physician</p>		<p>10. Name of funeral director</p>	
<p>11. Name of next of kin</p>		<p>12. Name of informant</p>	
<p>13. Name of registrar</p>		<p>14. Name of registrar</p>	
<p>15. Name of registrar</p>		<p>16. Name of registrar</p>	
<p>17. Name of registrar</p>		<p>18. Name of registrar</p>	
<p>19. Name of registrar</p>		<p>20. Name of registrar</p>	
<p>21. Name of registrar</p>		<p>22. Name of registrar</p>	
<p>23. Name of registrar</p>		<p>24. Name of registrar</p>	
<p>25. Name of registrar</p>		<p>26. Name of registrar</p>	
<p>27. Name of registrar</p>		<p>28. Name of registrar</p>	
<p>29. Name of registrar</p>		<p>30. Name of registrar</p>	
<p>31. Name of registrar</p>		<p>32. Name of registrar</p>	
<p>33. Name of registrar</p>		<p>34. Name of registrar</p>	
<p>35. Name of registrar</p>		<p>36. Name of registrar</p>	
<p>37. Name of registrar</p>		<p>38. Name of registrar</p>	
<p>39. Name of registrar</p>		<p>40. Name of registrar</p>	
<p>41. Name of registrar</p>		<p>42. Name of registrar</p>	
<p>43. Name of registrar</p>		<p>44. Name of registrar</p>	
<p>45. Name of registrar</p>		<p>46. Name of registrar</p>	
<p>47. Name of registrar</p>		<p>48. Name of registrar</p>	
<p>49. Name of registrar</p>		<p>50. Name of registrar</p>	
<p>51. Name of registrar</p>		<p>52. Name of registrar</p>	
<p>53. Name of registrar</p>		<p>54. Name of registrar</p>	
<p>55. Name of registrar</p>		<p>56. Name of registrar</p>	
<p>57. Name of registrar</p>		<p>58. Name of registrar</p>	
<p>59. Name of registrar</p>		<p>60. Name of registrar</p>	
<p>61. Name of registrar</p>		<p>62. Name of registrar</p>	
<p>63. Name of registrar</p>		<p>64. Name of registrar</p>	
<p>65. Name of registrar</p>		<p>66. Name of registrar</p>	
<p>67. Name of registrar</p>		<p>68. Name of registrar</p>	
<p>69. Name of registrar</p>		<p>70. Name of registrar</p>	
<p>71. Name of registrar</p>		<p>72. Name of registrar</p>	
<p>73. Name of registrar</p>		<p>74. Name of registrar</p>	
<p>75. Name of registrar</p>		<p>76. Name of registrar</p>	
<p>77. Name of registrar</p>		<p>78. Name of registrar</p>	
<p>79. Name of registrar</p>		<p>80. Name of registrar</p>	
<p>81. Name of registrar</p>		<p>82. Name of registrar</p>	
<p>83. Name of registrar</p>		<p>84. Name of registrar</p>	
<p>85. Name of registrar</p>		<p>86. Name of registrar</p>	
<p>87. Name of registrar</p>		<p>88. Name of registrar</p>	
<p>89. Name of registrar</p>		<p>90. Name of registrar</p>	
<p>91. Name of registrar</p>		<p>92. Name of registrar</p>	
<p>93. Name of registrar</p>		<p>94. Name of registrar</p>	
<p>95. Name of registrar</p>		<p>96. Name of registrar</p>	
<p>97. Name of registrar</p>		<p>98. Name of registrar</p>	
<p>99. Name of registrar</p>		<p>100. Name of registrar</p>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> c. LENGTH OF STAY IN 1b <u>Ellicott City</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>391 Frederick Road</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> d. STREET ADDRESS <u>391 Frederick Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>GRACE BUCHANAN MALONE</u> First Middle Last			4. DATE OF DEATH <u>March 30, 1959</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Catonsville, Md</u>	
13. FATHER'S NAME <u>John Buchanan</u>			14. MOTHER'S MAIDEN NAME <u>Rosella Gosnell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. R. D. Wilson, Baltimore 29, Md.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>463X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PHLEBOTROMBOSIS, RT. LEG</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> <u>1 DAY</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Donald E. Fisher M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-31-59</u>	
EXAMINER'S NAME (Type) <u>Donald E. Fisher M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	
22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don</u>		ADDRESS <u>28</u>			

3201

CERTIFICATE OF DEATH

03194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Daniels</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Daniels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL HARRISON Mc CAULEY</u>		4. DATE OF DEATH Month Day Year <u>March 20, 1959</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Leesburg, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walter S. Mc Cauley</u>		14. MOTHER'S MAIDEN NAME <u>Susie Allison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, & unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-4967</u>	
17. INFORMANT <u>Mrs. Florence Mc Cauley, Daniels, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/28</u> , 19 <u>58</u> , to <u>3/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>59</u> , and that death occurred at <u>11:00 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>446 Church St. Ellicott City, Md</u> DATE SIGNED <u>3/21/59</u> ACTUAL SIGNATURE <u>Thomas F. Herbert M.D.</u> PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert M.D.</u> <u>Ellicott City, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		24a. REC'D BY REGISTRAR <u>MAR 23 '59</u>	
ADDRESS <u>Ellicott City, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3202

CERTIFICATE OF DEATH

03195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLESVILLE MD</u>				c. LENGTH OF STAY IN 1b <u>X COLESVILLE MD RFD 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COLESVILLE MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY GIRL WALLACE</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLOI</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 8 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LEROY Parker</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Conroy Parker Laurel R. F. O</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.0</u> DUE TO <u>5 suffocation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unattended birth</u> (c) <u>30 min</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <u>3/8</u> , 19 <u>59</u> , to <u>3-8</u> , 19 <u>59</u> , that I last saw the deceased on <u>3/8</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. W. L.</u>				ADDRESS (Street, city or town, state) <u>3-8-59</u>			
PHYSICIAN'S NAME (Type) <u>Ridge Kelly 1200 Snowden Place</u>				DATE <u>MAR 10 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spells Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridge Kelly 1200 Snowden Place</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

5103

W. C. D. 1111

DATE

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

TIME OF BURIAL

PLACE OF INTERMENT

DATE OF INTERMENT

TIME OF INTERMENT

PLACE OF CREMATION

DATE OF CREMATION

TIME OF CREMATION

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TIME OF REINTERMENT

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Rural		c. LENGTH OF STAY IN 1b Box 204		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 204		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM FRANCIS RILEY		4. DATE OF DEATH Month March		Day 18		Year 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 60 yrs.	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardyman		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Arthur Seatch, Laurel, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 (c) partial		INTERVAL BETWEEN ONSET AND DEATH Partial		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) partial		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) partial		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) partial		20f. (City or town) Laurel		(County) Howard		(State) Md		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 19, 1959		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORY Garage Cem.		22d. LOCATION (City, town, or county) Laurel, Md		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Davidson, Laurel, Md		ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume		24c. DATE MAR 24 '59		24d. SIGNATURE Arthur L. Hume		24e. DATE MAR 24 '59		24f. SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

1910

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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3204

CERTIFICATE OF DEATH

03197

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup, R.F.D. Mission Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mission Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Frederick</u> Last <u>See</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Marshall, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George See</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Jesse S. See</u> Address <u>Jessup Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>481X</u> DUE TO (b) <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Influenza</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Serility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>8 years</u> <u>1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 14, 1959</u> to <u>Mar. 15, 1959</u> , that I last saw the deceased alive on <u>Mar. 14, 1959</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mark E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>3/15/59</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clinton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Marshall W. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Randalson</u> ADDRESS <u>Ramel, Md</u>		24a. REC'D BY REGISTRAR <u>MAR 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

CERTIFICATE OF DEATH

0301

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

1. Name of deceased: *John W. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15, 1900*

5. Place of birth: *Boston, Mass.*

6. Date of death: *Dec 10, 1945*

7. Place of death: *Home*

8. Cause of death: *Heart disease*

9. Duration of illness: *2 weeks*

10. Name of physician: *Dr. J. H. Brown*

11. Name of funeral home: *Smith & Son*

12. Name of informant: *John W. Smith*

13. Address of informant: *123 Main St., Boston, Mass.*

14. Signature of informant: *[Signature]*

15. Date of filing: *Dec 15, 1945*

16. Name of registrar: *[Signature]*

17. Name of clerk: *[Signature]*

18. Name of auditor: *[Signature]*

19. Name of chief clerk: *[Signature]*

20. Name of assistant clerk: *[Signature]*

21. Name of stenographer: *[Signature]*

22. Name of typewriter: *[Signature]*

23. Name of messenger: *[Signature]*

24. Name of janitor: *[Signature]*

25. Name of porter: *[Signature]*

26. Name of watchman: *[Signature]*

27. Name of night watchman: *[Signature]*

28. Name of caretaker: *[Signature]*

29. Name of gardener: *[Signature]*

30. Name of cook: *[Signature]*

31. Name of maid: *[Signature]*

32. Name of laundryman: *[Signature]*

33. Name of shoemaker: *[Signature]*

34. Name of tailor: *[Signature]*

35. Name of hatter: *[Signature]*

36. Name of druggist: *[Signature]*

37. Name of pharmacist: *[Signature]*

38. Name of optician: *[Signature]*

39. Name of dentist: *[Signature]*

40. Name of veterinarian: *[Signature]*

41. Name of engineer: *[Signature]*

42. Name of mechanic: *[Signature]*

43. Name of electrician: *[Signature]*

44. Name of plumber: *[Signature]*

45. Name of carpenter: *[Signature]*

46. Name of painter: *[Signature]*

47. Name of bricklayer: *[Signature]*

48. Name of mason: *[Signature]*

49. Name of stone mason: *[Signature]*

50. Name of ironworker: *[Signature]*

51. Name of welder: *[Signature]*

52. Name of blacksmith: *[Signature]*

53. Name of cooper: *[Signature]*

54. Name of joiner: *[Signature]*

55. Name of cabinetmaker: *[Signature]*

56. Name of upholsterer: *[Signature]*

57. Name of saddler: *[Signature]*

58. Name of harness maker: *[Signature]*

59. Name of shoemaker: *[Signature]*

60. Name of hatter: *[Signature]*

61. Name of druggist: *[Signature]*

62. Name of pharmacist: *[Signature]*

63. Name of optician: *[Signature]*

64. Name of dentist: *[Signature]*

65. Name of veterinarian: *[Signature]*

66. Name of engineer: *[Signature]*

67. Name of mechanic: *[Signature]*

68. Name of electrician: *[Signature]*

69. Name of plumber: *[Signature]*

70. Name of carpenter: *[Signature]*

71. Name of painter: *[Signature]*

72. Name of bricklayer: *[Signature]*

73. Name of mason: *[Signature]*

74. Name of stone mason: *[Signature]*

75. Name of ironworker: *[Signature]*

76. Name of welder: *[Signature]*

77. Name of blacksmith: *[Signature]*

78. Name of cooper: *[Signature]*

79. Name of joiner: *[Signature]*

80. Name of cabinetmaker: *[Signature]*

81. Name of upholsterer: *[Signature]*

82. Name of saddler: *[Signature]*

83. Name of harness maker: *[Signature]*

84. Name of shoemaker: *[Signature]*

85. Name of hatter: *[Signature]*

86. Name of druggist: *[Signature]*

87. Name of pharmacist: *[Signature]*

88. Name of optician: *[Signature]*

89. Name of dentist: *[Signature]*

90. Name of veterinarian: *[Signature]*

91. Name of engineer: *[Signature]*

92. Name of mechanic: *[Signature]*

93. Name of electrician: *[Signature]*

94. Name of plumber: *[Signature]*

95. Name of carpenter: *[Signature]*

96. Name of painter: *[Signature]*

97. Name of bricklayer: *[Signature]*

98. Name of mason: *[Signature]*

99. Name of stone mason: *[Signature]*

100. Name of ironworker: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3205

CERTIFICATE OF DEATH

Reg. Dist. No.

03198

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> <u>Howard</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. LENGTH OF STAY IN 1b <u>42</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Commercial St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leon Harrison Sherman</u>		4. DATE OF DEATH Month Day Year <u>March 6 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1916</u>
9. AGE (In years last birthday) yrs. <u>42</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete mixing business</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Eugene M. Sherman</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Farrell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>213-12-2912</u>	
17. INFORMANT <u>Ross H. Sherman, High Ridge, Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Duodenal 1 yr - 153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>48</u> to <u>3/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/4/59</u> , 19 <u>59</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>John M. Warren</u>		PHYSICIAN'S NAME (Type) <u>John M. Warren</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 9, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAR 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

